



**ADVANCING THE PATIENT SAFETY AGENDA:
AN AUSTRALIAN PERSPECTIVE**

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INTRODUCTION

Australia, the United Kingdom, and the United States all face similar challenges in delivering high-quality health care—aging populations, increased prevalence of chronic disease, new and emerging technologies, and increasing public expectations.

Each of these countries also has experienced growing concerns about adverse events and a heightened emphasis on safety and quality. Yet, despite these common challenges, fundamental differences exist in the organization and financing of the health care sectors of these countries. Australia's mixed public-private health care system provides a unique opportunity to address safety and quality considerations across a spectrum of which the U.K. and U.S. systems represent two specific end points.

AUSTRALIAN CONTEXT FOR PATIENT SAFETY

Australia has a land mass roughly the same size as Western Europe or the United States (excluding Alaska), with most of the continent either uninhabited or sparsely settled. The population is highly urbanized, with the majority living in the major cities, along the fertile east and southeast coast of the continent, and in smaller inland regional centers. Since 1901, Australia has been an independent nation with a federal system of government that has its origins in the British system of government and law.

The health of most Australians is good and continues to improve. Australians enjoy one of the highest life expectancies in the world—82 years for women and 77 years for men in 2000. There have been increases in expected years of life of almost 30 years for men and 23 years for women during the 20th century. Death rates are continuing to decrease, and access to treatment and other services is generally improving. Regrettably, some groups in the population continue to suffer poor health, in particular indigenous Australians, who on average die more than 20 years earlier than other Australians—clearly an unacceptably high mortality rate (AIHW: 2002).

Australia has a complex health care system with a mix of services, providers, funding, and regulatory mechanisms. It is funded predominantly by the public sector. The commonwealth operates universal benefits schemes for private medical services (through Medicare) and for pharmaceuticals (through the Pharmaceutical Benefits Scheme), and other programs such as population health. The commonwealth also fosters and funds most of Australia's health care research and plays an important regulatory role, which includes

overseeing the safety and quality of pharmaceutical and therapeutic goods and appliances and regulating the private health insurance industry. Most physicians in Australia are engaged in private practice, which is regulated through Medicare and statutory and professional codes of conduct.

The six state and two territory governments, with commonwealth financial assistance, are mainly responsible for funding and administering public hospitals and regulating health care professionals.

There also is a large and vigorous private sector in the Australian health care system, which receives substantial direct and indirect government subsidies. Since the late 1990s, various commonwealth initiatives have encouraged a strengthened role for the private sector. Health insurance funds can cover private and public hospital charges and a portion of medical fees for inpatient services. Some 30 percent of hospital beds are provided by the private sector.¹ Nongovernment, nonprofit organizations also play a significant role in health services, public health, and health insurance.

In summary, the health care system in Australia is decentralized, pluralist, and complex. The states and territories administer and deliver many health services and provide funding for these services, while the commonwealth has continued to expand its policy, funding, and regulatory role, with an increasing role for the private sector as both funder and service provider.

Australia's federal system of government enables a range of models to develop and coexist. There are clear variations between state and territory health care systems in terms of their policies, structures, regulatory systems, and financing models. Policy can be firmly grounded in practice. At least some of the differences have evolved in response to different local conditions—such as the challenge faced by Western Australia and the Northern Territory in delivering health services to sparse but diverse populations across vast distances compared with the reverse in some other states and territories. These are welcome variations compared with variations in clinical practice that have no basis in evidence or patient needs.

There are also advantages attached to Australia's smaller population, which means that professional colleges and other key stakeholders can be accessed more readily to drive health care reform compared with health care systems in United Kingdom and United

¹ According to the Australian Institute of Health and Welfare, numbers of hospital beds are regarded as a more reliable indicator of the availability of hospital services than numbers of hospitals (AIHW. 2003;280).

States. This is not to say that Australia has followed a path of radical reforms to its health care system. The complexity of Australia's health care system means that health care reform is generally incremental and involves much lively public debate.

Finally, certain health care trends are highly relevant to patient safety. Length of stay in hospitals is decreasing with advances in health care, drug treatments, and medical technology, enabling a wider range of procedures to be performed on a same-day basis (Duckett 2002). Efforts to increase hospital productivity also have contributed to this trend, with the average length of stay in hospitals now less than four days, and with around half of hospital admissions involving same-day admissions to hospital (AIHW 2002:282). Treatments once requiring hospital admission are now provided in outpatient clinics and day-care facilities or by community health services.

These trends, together with demographic changes such as the aging of the population, mean that hospitals are increasingly providing services to patients needing higher levels of care, making the provision of safe and quality care for patients all the more challenging.

THE GENESIS OF EFFORTS TO IMPROVE PATIENT SAFETY IN AUSTRALIA

Health care systems throughout the world are searching for better ways to deliver care. While considerable effort has been placed on "value for money" and constraining growth in costs, safety and quality are now receiving increasing emphasis. Moreover, there is a growing focus on health care quality as a central function of health systems, not just an area of discretionary activity (National Expert Advisory Group on Safety and Quality in Australian Health Care 1999). The focus on quality reflects the increasing technical sophistication of modern health care, the expectation of the community as "better consumers," the scope for patients to be harmed by health care interventions, and the complex systems from within which health care is delivered (Wellington 1999).

In an Australian context, a systemwide focus on quality has been driven by a number of factors, notably the Quality in Australian Health Care Study (QAHCS), which suggests that a higher-than-expected number of admissions were associated with adverse events (Wilson et al 1995). Media reporting on problems with the safety and quality of health care also drew attention to the issues, although the effect of media attention is difficult to quantify.

The QAHCS has grounded Australia's patient safety movement in a debate focused on numbers of adverse events and systems and less on a debate around blaming the individual as in some other countries. When the same rate of adverse events is counted, most advanced health care systems have an in-hospital adverse event rate of around 10 percent.

ESTABLISHMENT OF THE SAFETY AND QUALITY COUNCIL

Australian health ministers² showed initiative and commitment in addressing the need to improve patient safety, culminating in the establishment of the Australian Council for Safety and Quality in Health Care in January 2000 (milestones in the development of the Council are summarized in [Appendix A](#)).

The council was established by commonwealth as well as state and territory health ministers, nine in all, to work in conjunction with key stakeholders to provide national leadership in systemwide approaches to safety and quality improvement in health care.

The council's vision for a safer health care system:

- is people-centered, so that patients feel comfortable as partners in their own health care, and teams of health care professionals are encouraged to work together effectively for the care of each patient;
- has a culture of learning for quality improvement, with honest and open communication, and mechanisms for measurement and reporting that provide data for system improvement and for accountability not only to patients but to managers, funders, and the community;
- supports multidisciplinary approaches and encourages development of practical initiatives that provide strategies and tools for improving safety and quality that can be implemented across the public and private systems, in hospitals, and in the community; and
- constantly strives to eliminate error and improve systems design to make health care safer.

² The Australian Health Ministers' Advisory Council (AHMAC), a committee of the heads of the commonwealth, state, and territory health authorities and the Commonwealth Department of Veterans' Affairs, is the major decision-making body on national health issues. AHMAC advises the Australian Health Ministers' Conference on Policy and Resourcing Issues. Several national bodies have been established by AHMAC or health ministers to provide leadership and advice on specific health areas such as public health and health information. The Australian Council for Safety and Quality in Health Care is the national body established by health ministers to lead national efforts to improve the safety and quality of health care.

Safety and quality improvement involves a genuine partnership with stakeholders at many levels, and this commitment to improvement means having a vision as well as putting in place practical strategies at all levels—with the ultimate aim of improving care for patients at the front line.

Acknowledging these imperatives, the council operates as a collaborative vehicle, involving all jurisdictions and many stakeholders in national efforts to improve the safety and quality of health care in Australia. The council has active involvement and support from all jurisdictions through nominated council membership and through financial contributions from all jurisdictions. The commonwealth provides 50 percent of the financial contribution with the other 50 percent provided by the states and territories on a per capita basis. The State Quality Officials' Forum, which is represented by all jurisdictions, supports the council's work.

The council works in collaboration with other national bodies and organizations involved in a wide range of areas to improve the safety and quality of patient care, including blood product safety, medical indemnity arrangements, and reducing the pressure on hospital emergency departments. A specific example is the expert advisory group that investigated claims that plasma testing positive to the hepatitis C antibody was used in the manufacture of plasma products for several months in Australia in 1990.³

Since its inception, the council has operated as a policy advisory body, successfully influencing change through a collaborative “third-party broker” approach and also identifying, coordinating, and funding action at all levels of the health care system. While the council is able to make recommendations, it is not able to mandate action or change, contrasting with the regulatory powers of governments for effecting change.

The council's national action plan provides a blueprint to achieve improvements in patient safety with a particular focus on:

- supporting those who work in the health care system to deliver safer patient care;
- improving data and information for safer health care;
- involving consumers in improving health care safety;
- redesigning systems of health care to facilitate a culture of safety; and
- building awareness and understanding of health care safety.

³ Bruce Barraclough was the chair of the expert advisory group, which reported in 2003.

AUSTRALIAN HEALTH CARE AGREEMENTS

The Australian Health Care Agreements (agreements) recognize the joint funding responsibility of the commonwealth, states, and territories to provide free public hospital services to Australians and to promote a national approach to health care policy.

The agreements demonstrate a real commitment by governments to improving the quality and safety of services for patients through the Quality Improvement and Enhancement Plans, which all states and territories have developed under the agreements. The commonwealth has invested some \$680 million under the 1998 to 2003 agreements to support improvements in quality and safety, strengthening the capacity of states and territories to undertake quality-improvement activities to improve care for patients within their public hospitals. As a result, there is a large platform of safety and quality activity in progress.

Australian health ministers have taken a new approach to the renegotiation of the next agreements, establishing nine reference groups of experts and officials to each address a specific area of health care policy to inform the agreements. The council was invited by the health ministers to report on safety and quality issues under the next agreements. The reference groups, which reported in September 2002, highlighted the significant changes that have occurred in clinical practice and the organization and delivery of health services during recent decades, including shifts in the relative roles of the public and private sectors.

Opportunities for improvement identified by the reference groups include:

- the need for further improvements in safety and quality to support the delivery of the best possible health care;
- the need for a well-trained workforce that collaborates across health care sectors and professional boundaries; and
- consumer-centered health care planning and delivery models that promote self-management and informed decision-making.

These issues are informing the deliberations of Australia's health ministers in the lead-up to the next agreements. The next agreements, which are due to commence in mid-2003, will include further funding for quality and safety improvement. The council will advise on the use of this funding by states and territories.

THE COUNCIL'S ACHIEVEMENTS AND CHALLENGES

The council has made considerable advances in gaining acceptance of and commitment to the health care safety improvement agenda by all involved in health care. Since its inception, the council has emphasized the need for a systems approach to improving patient safety into the future, and constant vigilance for new opportunities for improvement given the complexity of the health care system. The council's message has been that poor quality of care drains the system of precious resources, leads to significant human costs, and erodes public confidence, as the public already expects safe and high-quality care wherever it is given.

Many stakeholders have been involved in the council's efforts to change culture. The council's positioning in a dominant leadership role has helped it to successfully build a culture of safety through its visible leadership and consistent messages about systems safety and improvement. As a result of these efforts, there is now an increased willingness to recognize adverse events and a reduced tolerance of them. Individual jurisdictions are also making significant efforts to improve patient care as evidenced by a review of progress against the Quality Improvement and Enhancement Plans under the Australian Health Care Agreements.

Highlights of the council's work program include ([Appendix B](#)):

- *Medication safety initiatives.* The council is leading national work to improve medication safety in Australia and is providing more than \$7 million in funding support to drive improvements in this area. Some specific initiatives are:
 - › *The Medication Safety Breakthrough Initiative.* The council is using the Breakthrough Collaborative Methodology developed by the U.S.'s Institute of Healthcare Improvement to reduce patient harm from medication use by 50 percent within 12 months. The council is supporting organizations through education and networking mechanisms throughout the initiative, which commenced in April 2003.
 - › *Medication Safety Innovation Awards Program.* A complementary stream of funded activity is being supported by the council to enable health care organizations to implement innovative, evidence-based approaches to reduce patient harm from medication use. This program recognizes the diversity of academic thought and clinical approaches to improve medication safety.

- *Greater openness when things go wrong.* Effective and compassionate communication by health care providers to patients and their carers is essential for the provision of safe health care. Extensive consultation has been undertaken across Australia to develop national standards and guidelines to support open disclosure by health care providers to patients and their carers when things go wrong. Education and organizational support packages are also being developed, which will assist in the implementation of the standards. The draft open disclosure standard has been approved as a national standard and will now be implemented with the support of the council.
- *Educational strategies.* Education is one of the key elements for redesigning systems and facilitating a culture of safety in health care. The council recognizes the need for health care professionals to learn about risk management, human factors, a systems approach to safety, and communication and teamwork within complex systems. The council is leading a program of work around education in health care safety, including in relation to undergraduate medical and nursing education, postgraduate education through professional colleges, and continuing education and training. The council is presently commissioning a project to develop a National Framework for Education on Patient Safety, which will define the competencies (skills, knowledge, and behaviors) required for patient safety for all of those working in the health care sector.
- *Safety Innovations in Practice (SIIP) Program.* Through this program, the council has funded health care providers at a local level to undertake targeted initiatives to improve health care safety. The council has funded more than 60 projects nationally in hospitals and health care organizations in a wide range of areas, including medication safety and systems redesign. A report containing the results of the first round of projects has been disseminated nationally to ensure the resulting innovative tools and approaches are widely promoted.

After encouraging results from the first round of SIIP in 2002, a second round was funded in 2003 made up of 65 projects valued at around \$2 million in priority areas such as safe staffing and involvement of consumers in health care safety. The council is currently considering a third round of SIIP.

There is significant momentum among health care professionals who are committed to and active in making a difference for safety and quality within their

organizations and across the health care system. Their continuing effort and teamwork is the necessary groundwork for identifying system vulnerabilities and learning from them.

While considerable progress has been made in building a culture of safety, there are still challenges to be met in order to prevent patients from being harmed in the course of their encounters with the health care system. Answering these challenges requires long-term commitment and action by all engaged in health care. These include reform in the broader health care system to strengthen the capacity of the health care workforce, improve the use of information technology, and clarify and strengthen governance responsibilities for patient safety. There are significant areas that are beyond the capacity of the council to mandate or assure under its current structure and therefore the council relies on leadership from governments guided and influenced by the council.

THE COUNCIL'S PROPOSED FUTURE AGENDA

Health care safety is an emerging issue all over the world, as recognized by recent activities of the World Health Organization, with the complexity of safety improvement acknowledged as a major challenge in most countries. It is recognized internationally that significant investment will be required to change the way people work together and the way systems are governed and managed, wherever health care is delivered.

The council has recognized the need for sustainable, long-term improvement at all levels of the system, as well as the limitations of the existing infrastructure to support this in Australia.

Since its establishment, the council has:

- set the national agenda and raised awareness of the need for change;
- developed guidelines and standards to increase consistency at a national level; and
- demonstrated progress at the organizational and local levels in priority action areas.

However, there is currently no coordinated or sustainable way for these initiatives to be entrenched and assured within the health care system. The council advises in relation to problems, initiatives, and action and provides leadership for change and improvement, but it has no legislative powers. While the council has set the agenda for change and continues to provide national leadership, it has limited operational capacity and lacks statutory authority to embed a culture of safety at all levels. Jurisdictions have already played a major role in taking action and developing infrastructure to support safety and

quality improvement. The council recognizes that the ongoing role of jurisdictions and private sector organizations is fundamental to promoting culture change at the local level and improving health care services to patients.

INFRASTRUCTURE TO DRIVE THE LONGER-TERM PATIENT SAFETY IMPROVEMENT AGENDA

For sustainable change with the overall aim of providing health care that is safe, effective, and responsive, there needs to be:

- commitment to consistency and alignment of agendas at all levels;
- best-practice alignment of governance responsibilities for funders/purchasers, managers, and clinicians at all levels of the health care system;
- national standardization in areas of clinical improvement that have an impact on patient safety and standardization of protocols for local management at the health care facility level;
- investment in operational capacity, building on existing state and territory infrastructure;
- a culture that is open to learning from accidents and mistakes, including all forms of error, and from knowledge shared by other organizations or jurisdictions in the context of international understanding of safety and quality improvement;
- a health services research agenda for patient safety to inform national work on systems redesign and culture change; and
- significant commitment to and investment in systems redesign both within health care facilities and across a range of health care settings to ensure the uptake and wide dissemination of evidence-based safe practice.

The council is considering a range of options at different levels that would provide the infrastructure to continue and reinforce existing work and drive improvement in the longer term. These include:

- *A national patient safety research center*—Such a center would take forward the council’s strategic research agenda for evidence-based patient safety improvement, which would underpin all of the council’s present and future work. This would include disseminating and implementing information about existing evidence, building an evidence base for the longer term, and investing in research in new

areas. This is likely to be developed in collaboration with other major research funding agencies.

- *A national center for patient safety improvement*—The aim of the center would be to support national processes and activities for system improvement, to provide a repository for the collection and analysis of national safety and quality data, and to give a national picture of health care safety. An important element would be feedback of information to health care professionals, managers, funders, and consumers for systems improvement.
- *System capacity building*—These activities would build on existing infrastructure to support national coordination and widespread uptake of educational and technical support tools to drive improvements in patient safety at the local level. These would be coordinated by, and feed into, the Center for Patient Safety Improvement.
- *Accreditation and standard setting mechanisms*—These activities would provide centralized stewardship and coordination to enhance the rigor, credibility, and simplification of standards setting and accreditation processes.

The development of these strategies will significantly enhance the capacity of the system to implement the council’s policy initiatives, as current capacity across the system is insufficient. The council will continue to work with all levels of government, clinicians, and consumers to further develop these concepts to ensure efficient and expedient allocation of the council’s resources. Investment will be necessarily high in the establishment phase and needs to occur in tandem with the council’s ongoing policy development.

LESSONS, OPPORTUNITIES, AND CHALLENGES

As a national body, the council has played a unique role in setting the agenda for change across the Australian health care system by leading progress toward improved patient safety. Consistency of purpose, alignment of agendas, integration of activity, and sharing of ideas, skills, and tools are all important in driving the overall agenda and ensuring sustainability.

It is important that data collection and analysis work are conducted with the aim of learning about system vulnerabilities and informing improvement. One of the important things the council has learned is that, as in aviation, higher reporting rates of errors may

actually show extra care and diligence by staff, so reports of errors alone cannot be used validly to assess hospital performance. The council is now clarifying its role regarding how to best add value to the information work being done in jurisdictions. Areas of activity include reaching agreement on a national core set of sentinel events, supporting training in root cause analysis, promoting a national approach to clinical audit as a quality improvement activity, and organizing a national workshop on performance indicators.

Another key lesson is that active consumer involvement is critical and can be achieved by supporting more informed decision-making for consumers and consumer involvement in health care improvement. Facilitating the redesign of systems to ensure that they are patient-centered is a core focus of the council's work. The council has taken a multilayered approach to ensuring that the experiences of consumers are effectively harnessed to drive improvements in the safety of health care. Specific council initiatives in this area include the Open Disclosure project; the consumer resource booklet "10 Tips for Safer Health Care"; initiating a national trial of consumer reporting of adverse medicine events; and improving the use of health care complaints information.

Strong consumer participation is vital to ensure that safety and quality improvements are practical and will make a real difference. Australia has a strong history of involving consumers in health care decision-making at a national level and has supported consumer bodies in a number of key policy areas. There has also been considerable effort to ensure that consumer feedback is used to improve the quality of care through requirements under the Australian Health Care Agreements; jurisdictions must have in place independent health care complaints commissioners and public hospital patient charters. More recently, there has been growing investment in Web-based information to assist consumer decision-making. Consumer involvement in improving health care is an area in which Australia has made significant gains and is well positioned to share its findings with its collaborators.

BARRIERS TO IMPROVEMENT

Although health care systems in different countries have contrasting structures, they face converging challenges. Significant barriers to safety and quality improvements in Australia include the following:

A. Culture of Blame

Blame does little to improve the safety of patient care; in fact, it drives problems underground. A culture of safety needs strong and visible leadership with a commitment to learning and improving systems rather than blaming individuals. Although much

progress has been made, much remains to be done to achieve a more just and open safety culture in Australian health care. A long-term sustained approach to culture change is needed. It needs to be recognized that even though reporting may be encouraged by anonymity and nonpunitive responses, any reporting system is still likely to be undermined by our legal system and a sensationalist press.

B. Unclear Governance Responsibilities

Greater clarity is needed about the responsibilities and accountabilities of health departments, health boards, managers, funders, and clinicians for improving the safety and quality of health care, particularly about the actions that should follow serious adverse events. Clear governance frameworks are essential. For example, the inquiry into the King Edward Memorial Hospital obstetrics and gynecological services (ACSQHC 2002a) found that, while the boards of management were responsible for the safety and quality of care provided by the hospital, there was poorly functioning governance of the system with unclear lines of authority and responsibility and a lack of accountability for clinical care and decision-making at government, management, and clinical levels. This resulted in poor staff and patient outcomes and persistent failure to act on known problems, despite the best efforts of many of the people involved.

C. Complexity of Health Care Service Provision

The complexity and intensity of health care service provision, which is based on cottage industry lines with significant clinical autonomy, creates a significant barrier to the creation of new organizational and management forms. Whereas in other industries new organizational forms and product improvements have emerged through the application of new technology (particularly information technology), rapid process improvements have not been as dramatic in health service delivery (Leatherman and McLoughlin 2001).

OPPORTUNITIES FOR CHANGE

The council needs to provide ongoing national leadership to build on the significant program of work already in progress through jurisdictions and through collaborative work with key stakeholders, including professional colleges and consumer organizations. The overarching goal is to measurably improve front-line services by reducing patient harm in areas such as serious adverse events, health care-associated infections, medication errors, inappropriate use of blood, patient falls, and pressure ulcers.

Key opportunities for reform to improve patient safety in Australia include the following:

A. Building the Evidence for Patient Safety Improvement

Health care is a complex adaptive system and assumptions about what works and what does not need to be tested (Cummins & McIntyre 2002). A national agenda for patient safety is needed to inform work on systems redesign and culture change, with an emphasis on uptake of research findings into health care practice. At its core, the research agenda should strive to create a culture of safety while identifying risk management opportunities and better ways to care for patients.

The council is developing a national patient safety research agenda with jurisdictions and key stakeholders, including the National Health and Medical Research Council and others. The Australian agenda will be informed by and collaborate with international developments such as the patient safety research program of the U.S. Agency for Healthcare Research and Quality and developments in the United Kingdom led by the Department of Health and the Medical Research Council. Part of the research agenda includes identifying and refining the business case for quality. It will also need to investigate effective community reporting given the risk averse nature of politicians and the public in relation to health care safety.

B. Developing a New Accountability Framework for Health Care Governance

The council has made considerable advances in gaining acceptance of and commitment to the health care safety improvement agenda. However, if the council is to be fully effective in improving services for patients, governance responsibilities for patient safety must be clarified and strengthened, and the public must be fully informed about these accountabilities.

Governance responsibilities for health care boards, managers, funders, and clinicians at all levels of the health care system (national, state, territory/local, and facility level) should be reviewed and aligned with best practices to create a new and nationally consistent accountability framework.

The new accountability framework would support a more just, transparent, and open safety culture in Australian health care by ensuring that health care professionals are supported and provided with appropriate protection when reporting on sentinel (serious) adverse events, for example. The community should be informed of organizations' risk management plans (including clinical risk management), which should represent the patient-centered, safety-focused values of the organization.

Consideration should be given to reflecting the new framework in contractual agreements between those responsible for patient safety, e.g., directors general and health care boards and their managers, to ensure the framework is embedded in day-to-day management and that it is on a par with accountabilities in place for financial management.

C. Facilitating Standardization at the National and Local Levels to Improve Patient Safety

There must be agreement to achieve national standardization in areas of clinical improvement that affect patient safety. There are many areas in which a consistent national approach would be beneficial, including in relation to:

- national definitions and minimum data sets;
- incident reporting and management;
- performance review criteria;
- information management systems; and
- standards setting.

Standardization of protocols in local management at the health care facility level would also yield wide-ranging benefits—from improving the safety of infusion pump use to helping to eliminate wrong patient, wrong procedure, and wrong site surgery. Initiatives in this area could include introducing incident reporting into health care facilities and improving processes for local review of deaths and adverse events.

D. Increasing Investment in Systems Redesign

Patient care is made up of many interrelated processes. Even minor changes in one part of the system can have significant consequences elsewhere. This means that improvements in patient safety require far greater attention to effective implementation and ways of simplifying processes and systems of care.

Investment in system redesign through research, development, and effective management of change is negligible compared with investment in other areas such as health care technology. Systems and processes of care can quickly become outmoded and fail to deliver safe care in the face of a rapidly expanding knowledge base, the introduction of new technologies, and rising consumer expectations. For example, investment in the development of state-of-the-art guidelines should be followed up with the redesign of processes and systems of care as well as ongoing evaluation of the “shelf life” of the

guidelines. Simply issuing guidelines to staff is likely to result in their ad-hoc adoption, an added burden and further complexity, rather than improving outcomes for patients. System redesign is needed both within the hospital and across a range of health care settings.

CONCLUDING OBSERVATIONS

Council leadership, with explicit government support and funding, has promoted strategies to improve safety and health care quality, which have made a significant difference to patient care and have placed Australia well internationally. At their core, these strategies have aimed to improve services for patients at the front line. Continued investment of resources and effort to improve safety and quality are essential to achieve change.

While national approaches are important, the diversity of health care settings in Australia means that there is no “one size fits all” solution. Nor will any one set of strategies be sufficient to fix every problem in the future. Improving the safety and quality of health care is urgent—but it is also a long-term effort that will need constant vigilance, given the complex and dynamic nature of health care.

Improving the safety and quality of health care is also an international agenda with significant benefits arising from global collaboration and sharing of experience. There are clear advantages in each country contributing to others’ efforts to develop tangible and practical solutions to address common challenges. The benefits include avoiding the need to “reinvent the wheel” and increasing the possibility of delivering greater benefits to patients than each country can deliver alone. This may be most appropriately stimulated by joint activities in patient safety and broader health services research.

Safety and quality improvement activities will continue to focus on the patient as the central and most important element of health care, while supporting health care professionals to give the very best care they can, given their impressive skills and professional dedication. Long-term commitment from policy-makers and health care professionals with empowered leadership and adequate resources at all levels will be needed to drive the agenda for systems change, as well as promoting widespread sharing and uptake of accepted strategies and processes for improvement. Our goal must be to embed patient-centered, safety-focused values in the culture of every health care setting, but most particularly as part of the core value set of those providing governance of the health care system.

Commitment to the patient safety agenda and to long-term, sustainable improvement in safety and quality can be demonstrated through investment in infrastructure and capacity building. This should occur through improvement in governance arrangements, underpinned by appropriate values and by collaboration to promote national consistency in the development and implementation of local policies.

Working together with shared patient-centered, safety-focused values, we can deliver sustainable and exciting improvement in health care.

**APPENDIX A. MILESTONES IN THE DEVELOPMENT
OF THE SAFETY AND QUALITY COUNCIL**

June 1995	Preliminary findings of the Quality in Australian Health Care Study (QAHCS) indicate a disturbing number of preventable deaths and injuries occurring in hospitals and in community settings.
June 1995	In response to findings of the QAHCS, health ministers establish the Taskforce on Quality in Australian Health Care to make recommendations for reducing the incidence and effects of preventable adverse events.
June 1996	The taskforce delivers its final report to the health ministers, recommending that a national safety and quality organization be established.
October 1996	The health ministers set up the National Expert Advisory Group on Safety and Quality in Health Care to coordinate and oversee national initiatives in safety and quality in health care and oversee the ongoing implementation of the taskforce's recommendations.
July 1999	The final report of the expert group provides advice to the health ministers about national actions that should be taken to improve the safety and quality of health care in Australia. It recommends that the health ministers establish the Australian Council for Safety and Quality in Health Care to facilitate coordination of those national actions.
January 2000	The health ministers agree to establish the council to provide national leadership and coordination of efforts to improve the safety and quality of health care.
February 2000	The council sets priorities for action that form the basis of the National Action Plan 2001, the first nationally agreed upon "blueprint for change," which was released in February 2001.

APPENDIX B. HIGHLIGHTS FROM THE WORK PROGRAM OF THE SAFETY AND QUALITY COUNCIL

The council's multifaceted program of work focuses on its priority action areas, as outlined in the body of this paper. This appendix highlights significant council achievements within these priority areas.

Charting the Safety and Quality of Health Care in Australia

This project aims to research, develop, and produce the first Australian version of the *Quality of Health Care in the United States: A Chartbook* (Leatherman and McCarthy 2002), to be known as *Charting the Safety and Quality of Health Care in Australia*. The project will progress under the auspices of the council, the National Health Priority Action Council (through the National Health Performance Committee), and the National Institute of Clinical Studies.

The purpose of *Charting the Safety and Quality of Health Care in Australia* is to provide clear and accurate information to the community that explains available data on the safety and quality of health care in Australia. The report will be written in vernacular English and will be “user-friendly.”

Improving Medication Safety

Improving medication safety in Australia is one of the council's priorities for 2001 to 2003. In Australia, it has been estimated that inappropriate medication use results in at least 80,000 hospital admissions each year at a cost of around \$350 million. The council has endorsed two streams of funding to achieve outcomes in this area:

National Medication Breakthrough Collaborative—The collaborative's overall objective is to measurably reduce patient harm associated with medication use by 50 percent in one year by supporting the implementation of system and process redesign to improve care in participating health care organizations. The collaborative will commence early or mid-2003 and is planned to run for up to two years.

Medication Safety Innovations Awards Program—This program provides health care organizations with funding (between \$60,000 and \$100,000) to implement innovative, evidence-based approaches to reduce patient harm from medication use. Ensuring sustainable improvement that can be applied more widely is a key element of this initiative.

Projects funded through this initiative are required to address one or more priority areas for action as identified by the council’s Medication Safety Taskforce, including:

- clinical teams using high-risk drugs;
- priority patient groups; and
- improving the continuity of care between health care organizations and the community.

Specific projects funded through this initiative include:

- reducing the potential for patient harm through improved insulin administration procedures;
- proactive risk management and computer-facilitated academic detailing by pharmacists;
- an integrated model for improving medication safety in children; and
- improving medication management by high-risk patients after discharge from the hospital.

Consumer Reporting of Adverse Medicine Events—The council, in conjunction with organizations leading quality use of medicines in Australia, is supporting a trial on Consumer Reporting of Adverse Medicine Events (CRAME). The purpose of the trial is to provide the council with greater insight into the reasons behind adverse medication events, which will be used as feedback to health care professionals and consumers to help reduce patient harm associated with medication use.

The council’s national CRAME trial will be informed by a program conducted in Queensland, which demonstrated that consumer feedback can help in reducing harm associated with medication use.

Agreeing on Sentinel Adverse Events for Action

Sentinel adverse events are defined as those adverse events that cause serious harm to patients or those that have the potential to seriously undermine public confidence in the health care system. The council has worked closely with all jurisdictions to develop and agree on a national core set of sentinel adverse events, with the aim of facilitating learning and change across Australia to prevent recurrence and reduce risks to patients where possible. The proposed national approach will involve strong commitment and participation at the national, jurisdictional, and local health service level. Jurisdictions

agree on the following core set of sentinel events, which are considered suitable for national aggregation and analysis:

Agreed National List of Core Sentinel Events

1. Procedures involving the wrong patient or body part
2. Suicide of a patient in an acute in-patient unit
3. Retained instruments or other material after surgery requiring re-operation or further surgical procedure
4. Intravascular gas embolism resulting in death or neurologic damage
5. Hemolytic blood transfusion reaction resulting from ABO incompatibility
6. Medication error leading to the death of a patient that is reasonably believed to be due to incorrect administration of drugs
7. Maternal death or serious disability associated with labor or delivery
8. Infant discharged to wrong family

Supporting Open Disclosure

The council believes that greater openness, especially when things go wrong with health care, is critical to improving safety. Consumers were instrumental in the initiation and development of the council's National Open Disclosure Project.

Extensive national consultation has been a key part of the project, which has developed the "Open Disclosure Standard: a national standard for open communication in public and private hospitals, following an adverse event in health care" and accompanying education and organizational packages to support and promote implementation of the standard. The next phase of the project will commence soon and will involve trial implementation of the standard and supporting material.

Focusing on Credentials and Clinical Privileges

The council has developed "National Guidelines for Credentials and Clinical Privileges" to promote a consistent process for credentialing and clinical privileging processes in health care services.

The credentialing and clinical privileging process outlined in the guidelines aims to ensure that professionals have an acceptable level of knowledge, skills, attitudes, and competence consistent with standards established by their registrable or equivalent

profession and are practicing safely. The guidelines are also designed to incorporate procedures for ongoing performance assessment.

To support implementation and uptake of these guidelines, the council has commissioned the Credentials and Clinical Privileges Project to develop a national standard based on the guidelines; an organizational support package, including educational materials, to accompany the standard; and a communications plan to promote national uptake of these products.

Responding Effectively to Adverse Events

Root cause analysis is an incident investigation technique that is widely used in industry and health care to identify the causes of incidents and to guide the development of preventive strategies.

The Veterans Affairs National Center for Patient Safety (VA NCPS) in the United States has adapted the root cause analysis methodology for the health care sector and has developed tools to help health care workers conduct an investigation. This technique is taught and practiced in Veterans Affairs hospitals across the United States, and the development of training tools and the training is organized by the National Center for Patient Safety. This methodology has been modified with the permission of VA NCPS by the Institute for Clinical Excellence in New South Wales for use in Australia.

In March to April 2003, the council supported national workshops in root cause analysis as part of the Effective Responses to Adverse Events Program. The aim of these workshops was to develop a core of Australian trainers to lead root cause analysis training initiatives in their own jurisdictions and to identify options for the council to develop a national patient safety improvement strategy.

Evaluations from the participants and the trainers involved in the workshops will guide the council's future training and implementation programs. The council's future directions include the development and dissemination of standardized training tools, development of training competencies, and support for root cause analysis trainers and practitioners.

Improving Patient Outcomes Through Safe Staffing

The provision of health care is the result of many complex processes and much human interaction. The effect that management of staffing variables has on patient outcomes

therefore can be quite significant. In this context, the staffing variables include fatigue, skill mix, staffing numbers, supervision, and team harmony.

The council has formed a Safe Staffing Taskforce to lead national efforts to improve patient outcomes through the improved management of staffing variables. The taskforce has commissioned a major literature review on the topic to ascertain the extent of the problem, effective strategies, and gaps in knowledge/evidence where future research may be targeted. The literature review is not only looking at the health care sector but also other sectors where some of these issues have been addressed over time—for example, fatigue in the transport industries.

Small-scale focus groups and in-depth interviews with a range of clinicians have also been contracted. The results of this work in conjunction with the results of the literature review will inform the taskforce in developing its work plan. A discussion paper is about to be publicly released to consider these issues.

The Safety Innovations in Practice Mark II program targeted safe staffing as one of its theme areas. The council is hopeful that the successful projects in this area will also contribute to the body of knowledge on successful interventions to improve patient outcomes through the improved management of staffing variables.

Strengthening Qualified Privilege

The council is working closely with all jurisdictions to strengthen the integrity of the existing qualified privilege schemes because all states, territories, and the commonwealth have different qualified privilege (statutory immunity) legislation.

The council recently produced a National Report on Qualified Privilege. The report was designed to demystify qualified privilege and describe some quality improvement activities that have benefited from the privilege, because qualified privilege schemes and the role they can play in improving the safety of health care are not well understood.

The council has also commissioned work to investigate and, where feasible, develop consistent approaches to assessing applications for qualified privilege under the different schemes. Promoting greater national consistency in approaches to qualified privilege is another important part of supporting the integrity and understanding of the protection afforded and the resulting obligations.

Draft guidelines for public reporting and decision support tools for those administering qualified privilege schemes have been developed and are being finalized in consultation with state and territory health departments.

Developing a National Patient Safety Research Agenda

The Safety and Quality Council's primary focus is to facilitate safer care for patients through redesign of health care systems. An essential part of this is developing a national patient safety research agenda to build a robust evidence base that will underpin improvements in the safety of health care for patients in Australia. The council is committed to building a strategic patient safety research agenda that will have a strongly applied focus, aimed at practical systems improvements that will deliver safer health care services to patients. The council has recently formed a National Patient Safety Research Reference Group to consider and recommend ways of strengthening patient safety research in Australia.

One of the initiatives being proposed by the council is to establish a Center for Excellence in Patient Safety Research to be led by an internationally recognized, high-caliber chair. Research commissioned by the center would have an interdisciplinary focus, and the center would collaborate with sectors outside health care that have made significant advances in safety, such as commercial aviation. The topics for research funded by the Center would need to align with national priorities in improving patient safety. Ensuring the uptake and adoption of research outcomes, including through leadership and change management strategies, would be an integral part of every research topic.

Improving the Use of Coronial Data

The council recognizes that the findings and recommendations of coronial investigations into deaths due to adverse events contain valuable information that can be used to inform strategies to reduce preventable patient injury and death.

In 2002, the council engaged the Victorian Institute of Forensic Medicine to undertake a project to review the role of coronial death investigation processes in improving the safety and quality of health care. The project identified a number of recommendations for future work to improve the existing coronial investigative processes and to ensure that the coronial findings and recommendations can be used effectively for system improvement. The council will continue working with stakeholders to implement recommended improvements.

Improving the Use of Health Care Complaints Information

The council is working to ensure more effective and consistent management of consumer complaints across the system through the development of tools and processes that support both consumers and health care professionals.

The council is working with a number of organizations, including the Australia and New Zealand Council of Health Complaint Commissioners, to develop a project to promote quality improvement through the recognition of good practice in complaints management, with the New South Wales Health Care Complaints Commission as the lead agency. The primary objective of the project is to identify how health care services can effectively link quality improvement and consumer complaints. Future phases of this work will build on the recommendations for implementation of the guidelines and development training and support materials.

Preventing Patient Falls

The council is aware that there is an enormous amount of work already happening in the management of falls and is working at a national level to add further value and support in this field. One of council's aims is to identify good work happening locally and disseminate it nationally. An example of this is the work that Queensland Health has done to prevent patient falls.

The Falls Prevention Best Practice Guidelines for Public Hospitals and State Government Residential Aged Care Facilities were developed by Queensland Health and have recently been released. This useful document takes a practical approach to falls prevention in acute settings. The guidelines are based on best-practice principles in relation to falls prevention in that they recommend a multifactorial approach, individual assessment, and ongoing monitoring.

The council has distributed more than 6,500 copies of the guidelines in CD-ROM format to all public and private hospitals, nursing homes, and aged care residences. The council acknowledges that simply distributing the guidelines will not create change and has therefore devised a feedback form to assess areas in which the council may play a future role. There has been an overwhelmingly positive response, and feedback has been collated with future strategies to support implementation being planned.

Encouraging Local Innovation

The council's Safety Innovations in Practice Program (SIIP) has created a new level of enthusiasm and commitment to improve safety and quality in health care. The program

provides time-limited funding to health care providers to address areas for systems improvement to improve the safety of patient care in particular health care settings.

After encouraging results from SIIP Mark I in 2002, a second-round SIIP (“Mark II”) was funded in 2003. SIIP Mark II includes funding for 65 projects in the following priority areas:

- Safe staffing.
- Building on SIIP Mark I.
- Involvement of consumers in health care safety.
- Use of existing data and measurement to improve safe practices.

Educational Strategies for Safety Improvement

The council considers education to be a key lever for improving patient safety and one of the key elements for redesigning systems and facilitating a culture of safety in health care. In particular, the council recognizes the need for those who work in health care to learn about risk management; incident management; human factors; and a systems approach to safety, communication, and teamwork within complex systems.

The council has undertaken a number of preliminary development exercises relating to health care safety and quality education that have identified a variety of strategies to improve and promote safety and quality education. A common theme was the need for national direction on the required skills, knowledge, and behaviors for patient safety through a detailed and structured framework.

The council is commissioning a project to develop a National Framework for Education on Patient Safety that will define the competencies (skills, knowledge, and behaviors) required for patient safety for all those working in the health care sector.

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